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**Indiana's Health Care
Sector and Insurance
Market: Summary
Report**

Final Report

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PROLOGUE

This report summarizes a series of reports investigating Indiana's health care economy and markets.

Reports in this series include: *Indiana's Health Care Sector and Economy*, *Indiana's Health Insurance Market*, *Employer-Sponsored Coverage in Indiana*, and *Factors that Drive Health Care Costs in Indiana*. The authors wish to thank Cynthia Collier and Seema Verma for guidance in the preparation of these reports and their thoughtful comments on early drafts.

INDIANA'S HEALTH CARE SECTOR AND INSURANCE MARKET:

SUMMARY REPORT

Indiana is undergoing demographic and economic changes that are likely to affect the affordability and structure of private health insurance. The state has a high birth rate while, paradoxically, the average age of the population is rising. As a result, the ratio of children to workers in Indiana is rising, as are health care costs for adults as the baby boom enters their 50s and 60s. In Indiana, as nationally, the relatively fast growth of lower-paying service jobs will make the problems that low-wage workers have in obtaining health insurance increasingly apparent.

The health care sector accounts for 10 percent of private employment in Indiana. This approximately equals the U.S. average and that in Illinois, but it is a smaller share of total private employment than in Kentucky, Ohio, and Wisconsin. Indiana's health care sector has been a welcome source of job growth even while jobs in other sectors disappeared in the recession years. The average wage for workers in health care services exceeds Indiana's average wage, though very high wages in relatively few jobs appear to account for both higher average and significant wage growth. Pay scales for physicians in Indiana are higher than either the national average or the average in most neighboring states, while pay scales for registered nurses are below the national average or the average in any neighboring state.

In a state as reliant as Indiana is on the production of health care services for jobs and income, health care cost containment is a mixed proposition. Rising health care costs probably depress employment and wages, and also drive increases in the rate of uninsured in Indiana. But reduced spending for health care services would reduce revenues to health care providers and threaten jobs in that sector. Our analysis of these effects indicates that the negative effects of rising health care costs in Indiana probably outweigh the economic benefits of revenues to health care providers and jobs in this sector, and that lower growth in health care costs would support net job creation. Roughly estimated, lower health care cost growth that ultimately achieved expenditure levels that are 25 percent less than projected would result in a net job gain of about 2 percent in Indiana—in 2002 equal to 52,000 net new jobs and a \$7.6 billion net increase in output and household income.

A reduction in health care costs as described above would also encourage greater offer and take up of employer-based health insurance in the state (an effect not measured in the above estimate). In turn, higher rates of coverage may reduce the burden of uncompensated care on health care providers. We estimate that a 25-percent reduction in uninsured (self-pay) hospital admissions would reduce the hospital charity care by 15 percent among the 50 percent of hospitals that account for the great majority of hospital charity care in the state. However even in these hospitals, bad debt accounts for 62 percent of uncompensated care. As a result uncompensated care among these hospitals would fall by just 9 percent.

OPTIONS FOR EXPANDING ACCESS TO PRIVATE INSURANCE

In compliance with federal law, nearly every state has enacted laws to improve access to employer-based coverage in compliance with the federal law requiring guaranteed issue and renewal of small-group policies and limiting preexisting condition exclusions. Researchers have failed to provide strong evidence most of these interventions have either increased or decreased rates of coverage, though some may help firms with higher-risk workers obtain coverage when they otherwise would be uninsured.

While federal law requires certain minimum regulations (such as guaranteed issue of group coverage), the states have discretion in other areas—including how insurers price small-group policies and the services or providers that group policies must cover. However, neither type of regulation has been shown to affect coverage levels. Thus, the consensus of research suggests that easing these regulations—allowing greater discounts to low-cost groups or the sale of “bare bones” policies—would not increase coverage significantly. Other state efforts—such as the subsidized small-group reinsurance programs in New York and Arizona—may show more promise, though for neither program have the impacts on coverage been formally evaluated. Both programs attempt to address cost barriers to coverage without compromising the value of the benefit.

Research on the individual market has identified some interventions that could be effective in expanding coverage. Comprehensive interventions—such as guaranteed issue in combination with community rating—may benefit individuals with health problems, but may reduce coverage overall if premiums rise significantly as a result. Nevertheless, the magnitude of effects on overall coverage is debated and may be negligible. Other interventions—such as reinsurance programs and high-risk pools—may be effective, although there is little empirical research to confirm their effects. However, it is reasonable to expect that larger programs would have greater impacts.

OPTIONS FOR EXPANDING ACCESS TO PUBLIC INSURANCE

In addition to efforts to expand private coverage, Indiana like many other states has worked hard to expand public coverage to low-income children, in particular. Concern about further expansions of Medicaid or Hoosier Healthwise (which covers children, pregnant women, and low-income working families) relates to concerns about extending the state’s fiscal obligations and also “crowding out” employer-based coverage, when low-income workers otherwise would have made greater effort to contribute to employer-based coverage if available for themselves and their dependents.

The research literature suggests that crowd-out is greater for public insurance programs that target higher-income populations than for Medicaid. The Medicaid expansions of the late 80s and early 90s resulted in crowd-out as of less than 25 percent among children. Estimates of crowd-out under the State Children’s Health Insurance Program (SCHIP) and under state expansion programs for adults—both of which reach families at higher levels of income—are typically in the range of 30 to 50 percent. Nearly all research suggests that the majority of low-income children and adults served by programs that target low-income families would have been uninsured in the absence of eligibility for public coverage.

POLICY TRADEOFFS

Considered as a whole, these research findings suggest difficult policy tradeoffs. Regulation making private insurance more accessible may raise the cost of coverage overall, making low-income families ever more likely to accept public coverage when it is available to them. For most states, finding a balance between access to private insurance and public coverage may be the most feasible path to improving coverage. In Indiana, this may entail accepting some crowd-out of private coverage among families for whom the cost burden of health insurance seriously threatens continuity of coverage and care, and also targeting assistance to workers and others who are high-risk, low-wage, or both.

All signs related to employer-based health insurance in Indiana point to a need for such targeted interventions. Returning to a long-term trend, employer coverage among Hoosiers under age 65 has fallen since 2000—apparently due to smaller numbers of workers obtaining coverage from their own employers. As is the case nationally, small establishments in Indiana have distinctively low rates of coverage, as do retail and general service establishments and establishments with many part-time or low-wage workers. The lack of employer offer in small firms remains an important obstacle to coverage in Indiana. Part-time workers (many of whom may piece several jobs together to work full-time) and low-wage workers have additional problems: they often are ineligible for coverage and, if eligible, often do not take it up.

For the large majority of firms in Indiana, health insurance premiums continue to rise—in 2002 more than 12 percent for single coverage. Recent premium growth in small firms and low-wage establishments suggests that they have pared back benefits to control premiums—probably raising plan deductibles, copayments, and out-of-pocket limits. As a result, average premiums in small firms and in low-wage establishments converged to the statewide average in 2002. But employee contributions were much higher in small firms and in low-wage establishments, further evidence that insurers are using greater cost sharing at the point of service to address both rising premiums and greater adverse selection. Employees likely to pay such high contributions are also more likely to need health care.

It may be important for Indiana policy makers to consider the consequences of this trend in terms of the value of coverage to workers for whom the benefits may seem increasingly remote and costly to access. Increased cost sharing is unlikely to ease wage suppression in Indiana significantly, as premiums continue to rise faster than wages in the state. But steadily rising premiums and high employee contributions to coverage strongly discourage coverage among low-wage workers in particular. Lack of coverage and inadequate coverage among those who remain insured are likely to reduce the use of preventive and chronic care (which may already be lower than desirable in Indiana), contribute to low population health status, and increase avoidable hospital admissions.

Although health care spending in Indiana, as in the rest of the country, has risen quickly, average per capita health care expenditures in Indiana may still be near the national average. This is an advantageous position from which to consider steps to improve health care financing and address future cost growth.

HEALTH CARE COST DRIVERS IN INDIANA

Key cost drivers in Indiana appear to include population health status and the cost of hospital care. Adults aged 45 to 64 are the fastest-growing segment of Indiana's population, and they have shown the greatest increases in some very costly diseases—including heart disease, diabetes, hypertension, and cerebrovascular disease. Smoking and obesity are more prevalent in Indiana than in the nation as a whole, increasing the severity of chronic conditions and contributing to Indiana's high rates of lung cancer and pulmonary conditions—both extremely costly. Greater incidence of these diseases has been linked to growing expenditure for hospital care in Indiana, and to much greater use of prescription drugs nationally.

The high cost of hospital care in Indiana appears to be related to both the high supply of hospital beds and high technological capacity. Both may drive higher greater expenditure for hospital care in Indiana than the national average. Most striking are the likely cumulative impacts of Indiana's higher bed supply, higher staffing per bed, higher costs per worker, longer lengths of stay, and the excess capacity implied by lower use-to-capacity measures in the hospital sector. Inefficient duplication of high-cost technology across hospitals apparently also contributes to high and growing hospital expenditures in Indiana.

Indiana hospitals in some locales recently have engaged in a burst of building and renovation that may further increase excess bed supply, inefficient replication of technology, and hospital cost. Nevertheless, there may be important opportunities for greater efficiency in the delivery and use of hospital care. A more detailed review of hospital staffing, length of stay, and duplication of technology in Indiana might find significant opportunities for reducing cost.

Indiana also has a very high supply of surgeons, suggesting a relatively aggressive style of care delivery that is consistent with Indiana's higher cost of hospital care. In contrast, per capita spending per capita for physician care in Indiana is lower than the national average or that in neighboring states. Although spending for physician care accelerated in 1998, use of primary and chronic care services may be lower than desirable in Indiana. Indiana might investigate the rate of avoidable hospitalizations to understand more clearly whether under-use of preventive and chronic care may contribute to the state's high hospital costs and low population health status.

Taken together, these findings suggest the need for policy makers in Indiana to address important challenges on multiple fronts. Important areas for immediate attention include greater efficiency in the delivery of hospital care, reducing the spending for hospital care that appears to be crowding out spending for other medical services. However, equally critical is attention to three problems that are more closely related than many policy makers may have appreciated: improving population health status, supporting adequate employer-based coverage among workers in small firms and low-wage jobs, and encouraging the appropriate use of preventive and chronic care.